The Hampden Hippocrat

Vol. XXXXII
No. 2

FEBRUARY / MARCH 1985

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As an organization accredited for continuing medical education, Baystate Medical Center certifies that this CME activity meets the criteria for credits in Category I for the Physician's Recognition Award of the American Medical Association (two hours credit per session).

March 16, 1985
"Gastritis: A Surgeon's Viewpoint"

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Professor & Chairman
Department of Surgery
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Philadelphia, PA

March 23, 1985
"Problems in biliary Surgery"

BJORN THORBJARNARSON, M.D.
Attending Surgeon
The New York Hospital
New York, NY

April 13, 1985
"The Death of Three Presidents"

WALTER J. PORIES, M.D.
Professor & Chairman
Department of Surgery
East Carolina University School of Medicine
Chief of Surgery
Pitt County Memorial Hospital
Greenville, NC

April 20, 1985
"Structure, Function and Outcomes of Trauma Center Management of the Multiply-Injured Patient"

JOHN H. SIEGEL, M.D.
Professor of Surgery
Johns Hopkins University
Director, Maryland Institute for Emergency Medical Services
Clinical Center
Baltimore, MD

April 27, 1985
"Issues in the Care of the Multiple Trauma Patient"

CHRISTOPHER BAKER, M.D.
Assistant Professor of Surgery
Yale University School of Medicine
Fellow, Timothy Dwight College
Attending Surgeon
Yale-New Haven Medical Center
New Haven, CT

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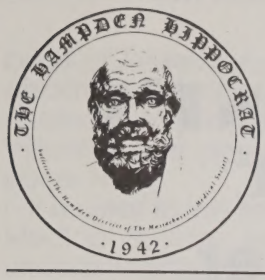

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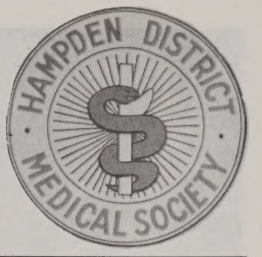

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THE HAMPDEN HIPPOCRAT IS PUBLISHED BI MONTHLY.

THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.

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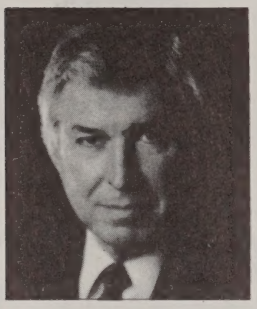

Lorne C. Smith, M.D.
President

PRESIDENT'S PAGE

Another Interesting Week

The recent visit of Dr. Harrison Rogers, President of the AMA was an unqualified success. On January 29th the meeting was attended by almost two hundred physicians and guests including most of the local legislators. His remarks were well received and made a favorable impression on all. The press and the TV coverage was the best we have ever had.

His address to the business leaders on Wednesday morning was well received. He impressed his audience with his grasp of a broad range of issues and his ability to articulate the role and importance of organized medicine in the fast changing world of healthcare in America today. We are fortunate to have a person of his stature and ability as the incoming President of the AMA.

Dr. Rogers had barely left Springfield, taking with him our gift of several live lobsters, when new problems developed.

On February 1, 1985 a "coalition" of organizations concerned with access of local medicaid patients to health care released to the media a plan designed to encourage or compel physicians to participate in the medicaid program. Their approach has been widely reported in the press and need not be repeated here. We knew nothing of this coalition or its plans until the press and TV stations called requesting a response.

After reviewing the press release, Dr. Terry Ryan and I responded. We advised that we are aware of access problems and that serious efforts are being made for improved access for medicaid patients. We want all patients to receive quality health care. We offered to sit down with the coalition and review a range of issues concerning medicaid, including physician participation. We said that we would welcome the cooperation of the coalition in attempting to influence the officials of the medicaid program and the Rate Setting Commission to make changes that would be likely to increase physician participation. We also offered the services of the H.D.M.S. to assist individual patients in obtaining care.

Immediately after the session, Dr.s Zadworny, Egan, Ryan, and I met with Commissioner Hurst of the Massachusetts Commission Against Discrimination. He had recently indicated that denial of care on the

continued on next page

basis of Federal Assistance could be a violation of Massachusetts discriminations laws. A cordial, informal discussion of many issues related to medicaid access took place. We felt that this meeting was valuable and opened an avenue of communication with Commissioner Hurst.

It is clear to me that we physicians, working with the Massachusetts Medical Society, must attempt to improve the real access of the underpriviledged to health care. The present environment of increasing hostility and polarization will benefit no one. This issue will, in my opinion, be our greatest challenge for 1985. I hope we are up to it. □

The Springfield Kiwanis Meets the AMA

During his two-day stay in Springfield, Dr. Harrison Rogers had his first occasion to speak to a Kiwanis Club as President-Elect of AMA on January 30, 1985. After singing "God Bless America", reciting the flag pledge, and eating lunch at "Lucky Pierre's", Dr. Rogers very ably presented a global picture of the AMA, its organization and its work in representing American Medicine to the public and to government. He presented to the attendees a review of the dynamic, changing forces in hospitals, health care delivery, medical education, governmental regulation and insurance. He noted the advances in medicine with lifespan increase, infant mortality decrease and technology explosion with its escalating costs.

Cures for the problems in healthcare, he emphasized, were going to come through Business-Medicine Coalitions, enlightened insurance carriers with cost containment benefits, an enlightened public, and concerned physicians. □

W.J. Baker, M.D.

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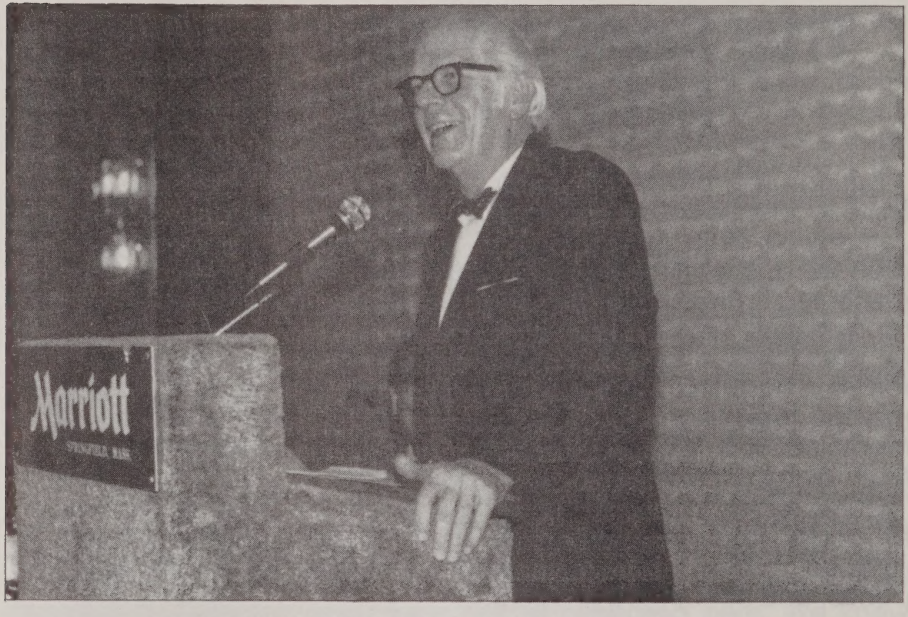
Dr. Rogers Speaks to the HDMS

Dr. Rogers urged all physicians to join the AMA to acheive full representation and have a genuine voice for Medicine in America.

William J. Baker, M.D.



DR. ROGERS SPEAKS AT THE HDMS MEETING JANURARY 29TH

The President-elect of the AMA, Harrison Rogers, MD, visited Springfield January 29 and 30 and spoke at the Hampden District meeting at the Marriott Hotel to a large group of physicians, legislators and spouses. His purpose, he stated, was to keep physicians in touch with AMA activities as well as to listen to the physicians for the AMA.

His half-hour remarks centered around current trends and problems perceived in Health care, and he recited just about all of them, from the physician's point of view, without too many plans for solution. Costs were the foremost concern of physicians, he felt, with the GNP rising from 6% for Healthcare to 10.8% over 20 years — currently about one billion dollars a day. With government paying 43% of the bill, budget cuts and Medicare fee freezes will really stimulate

continued on next page

attempts to make the Health care dollar stretch farther with decreases in Medical Education and Research finances, hospital services and physician reimbursement. He decried the Medicare fee freeze as an undesirable "quickfix", and felt that the AMA would never accept Health care "rationing".

He pointed out the changes in Health care delivery, the increasing competition among hospitals and even physicians and the fantastic technology boom with its high costs. He pointed out that the Atlanta area had more CAT scanners than all of England but expressed no opinion as to whether this was desirable or medically advantageous.

REP. IRIS HOLLAND AND MRS. HOUGH AT HDMS MEETING

He highlighted the escalation in medical malpractice judgements that were boosting premiums for professional liability insurance to 2 billion dollars a year, but more importantly, that were costing the public 30 billion dollars a year in defensive medicine or about 10% of the health care ticket. The AMA was working on this problem, he stated.

Dr. Rogers urged all physicians to join the AMA to achieve full representation and have a genuine voice for Medicine in America.

Dr. Rogers suggested that—

1. MD's and patients should be "on the same side."
2. MD's should be patients' advocates
3. MD's should resist commercialism.
4. MD's at all levels should be involved
5. MD's should defend quality care.

continued on next page

A brief question and answer period seemed to indicate that local MD's were more concerned with their pocketbooks than with Healthcare costs.

Dr. Rogers fielded questions about the fate of the private practitioner with the rapid spread of HMO's, PPO's and salaried MD's. He was asked the AMA's attitude towards the springing up of hundreds of "Doc in a box" centers — for profit urgent care centers. (The AMA feels that they're OK if they practice quality medicine). Finally, because of the onslaught of government plans to reduce or freeze physician reimbursements, President Reagan was called "no friend of medicine" as a delayed dessert was passed out to those who stayed. □

REP. WILLIAM MULLINS CHATS WITH DR. GARRY deN HOUGH

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Auxiliary News

We are happy to announce that our Child Passenger Safety Restraint is now on display at the Holyoke Children's Museum. Thank you, Debbie Calvanese and Audrey Rich.

Please plan to attend our 3rd Annual Continuing Education Seminar on March 21st at Springfield College from 9 A.M. to 4 P.M. Nursing credits will be given. This seminar is entitled "Families in Crisis". The featured morning speaker will be Warren Schumacher, Dean of the Center for the Family at the University of Massachusetts. The afternoon workshops, lead by other qualified professionals, will deal with the subjects of Families in Transition, Family Violence, and Family Decision Making. A brochure will be forthcoming in the mail.

Applications for scholarship aid in nursing and related health fields for 1985-86 are now being taken. Please call or write Mrs. Lorraine Penhos, 163 Elm Street, East Longmeadow 01028, 525-1654 for an application or more information. The applications deadline is April 1st.

Finally our Hampden District Medical Society Auxiliary will hold it's Annual Meeting and Luncheon with selection of officers on May 1st at the Colony Club this year. Watch your mail for further details and *please* try to attend. □

Julie Pohlman

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"Yes," a female voice answered. "For what city?"

"Doctor Noght in Springfield," he said. "I've got an emergency. A Medicare patient."

"Name please."

"John Noght."

"Patient's name...John Noght. Address?"

"No, no," he mumbled, uncertain. "I'm Doctor Noght. The patient's name is Anthony Zucchi. Z-u-c-c-h-i."

"Address for Mrs. Zucchi?" the lethargic voice asked.

"*Mister* Zucchi," he moaned. The wall clock read twelve ten, AM. "Fourteen Porter Road. It's diverticulitis."

"Is that near Worcester?"

"No. Next to the aortic bifurcation. Do you need his number?"

"Please read it slowly from the patient's card."

"Am I cleared?" he enquired, unaccustomed to asking a nurse for permission to operate.

"One moment please."

Soft paper shuffling sounds reached him through the receiver. He counted off two minutes and forty-five seconds on his digital watch. The Emergency Room receptionist jotted down the name of the patient, an upper gastrointestinal bleeder from what he could gather.

"You may admit your patient, Doctor Noght," she said cheerfully, "If he has the following findings..."

"Wait!" he didn't mean to scream. "I'm not calling to get permission to admit the patient. He needs an operation."

"One moment please..."

Twelve twenty A.M.

"Does your patient demonstrate any of the following...free air on upright plain abdominal x-ray? Massive hemorrhage requiring more than six units of blood? Total colonic obstruction?"

He thought for a long moment. Clinical medicine didn't seem to fit into neat catagories as well as it once did.

"Not really. It's an acute abdomen. He's really hurting."

"What does that mean? Abrupt abdomen?" Her voice refused a shred of emotional intonation.

"*Acute* abdomen," he exhaled. "He's sick and needs surgery."

"Is there free air..."

"Lady! There's no free air! Some patients perforate without demonstrating free air."

"Our manual is quite specific about free air, sir."

The receptionist handed him a computerized slip of paper. She informed a stooped nurse who was scribbling on someone's chart, about the bleeder.

"His white count's twenty-eight thousand," he read from the slip, chuckling inside with the new ammunition. "With a significant shift to the left." That should clinch it.

"With a what, Doctor?"

"You know, a shift to the left. He's got fifteen per cent bands. Even some toxic ganulations.:

"One moment please..."

"Does your manual discuss types of white blood cells, sweetheart?"

"Please remain civil, sir," she said with the enthusiasm of a Manatee. "White blood cell evaluation is a qualifier only. We don't list bands seperately. You are quite sure there is no free air?"

The surgeon stroked his receding hairline, staring in dismay as another grey strand floated to the floor. Without warning, a nurse rushed into the room housing Mr. Zucchi. "Look," he pleaded "can't you clear this case? He's in real trouble..." He waved to the receptionist, hand over the mouthpiece, "what's going on in there?"

"Our manual permits admission with intravenous fluid administration and broad-spectrum antibiotics. Perhaps your patient will show free air in the morning," the monotone continued.

"He'll be dead in the morning!"

"Aren't you being a little dramatic Doctor?"

"My patient's got a perforated sigmoid colon!"

"However, our manual..."

"Wait! Don't hang up!" He crosses to the room, then returns to the phone. "He's having a cardiac arrest! He's septic as hell!"

"One moment please." Before he can scream, she is back. "Your patient may be admitted to the coronary care unit after a cardiac arrest."

He bites four fingers to the periosteum. "My patient needs an operation."

"Sir, I will have to refer this case to my physician supervisor."

"Oh terrific," he groaned. "How long will *that* take?"

"He will call you within the hour."

"You'd better make it faster than that honey!"

"I'm terminating this call, Doctor."

The receptionist waved frantically, blurting out, "Don't hang up! Tell her we've got a bleeder coming in that's probably going to need surgery."

He eyed her, then replaced the phone in it's cradle. □

David W. Page, M.D. FACS

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Vocation or Avocation

In the halcyon days of yore, when Medicine was still a respected profession, no one begrudged physicians making a living because incomes were (and still are!) comparable to other professionals in the community and reflected the length of training, breadth of knowledge and expertise of the practitioner. Today it seems to be everyone's favorite sport to blame those innumerable faceless doctors (small d) for the financial ills of the American health care. One pundit, who does not deserve to be recognized, delighted recently at the thought that the Medicare fee freeze might mean that doctor's might not be able to meet payments on their second Mercedes. No one gives a thought to consumer demands, malpractice suits or advancing technology as possible contributory factors.

Meanwhile Doctors (and I still think we deserve a capital letter) struggle to provide care that is appropriate and timely, not prejudiced one way or the other by whether the patient has Medicare, Mass Mutual or Medicaid or whether Medical West has to be contacted before doing anything at all. Too often therapeutic decisions are forced on us by a faceless, and therefore, to carry the metaphor further, blind bureaucracy, who have rushed like Lemmings to the cost containment cliff. Only by incessant dialing of the ever burgeoning 800 numbers can one even begin to individualize health care any longer.

In the halcyon days of yore, Medicine was a vocation to be proud of, a profession that brought deep satisfaction from meticulous and careful practice. Leisure time was for one's avocation, be it golf, water sports, music, literature, or any one of a thousand hobbies that served to buffer the stress of the rest of the week. Even mowing those seemingly endless lawns and other mindless but nevertheless revitalizing chores, were worthwhile.

Today Medicine is no fun any more. At every turn someone is telling us what to do, how to do it, and for certain it better cost less. More and more physicians are looking from vocation to avocation in the hopes of avoiding the onrushing government health care monster. The office or apartment building, the development project or the retail outlet purchased as an investment and a hedge against inflation now begins to look pretty good as a primary income source. Tentative literary effort now looms tantalisingly as an alternative livelihood. Physicians are nurturing talents previously barely recognized and are turning to administration, business or even law as alternatives. The practice of medicine has now become that endless lawn — still potentially an object of pride and satisfaction, but a progressively arduous task to keep in shape.

Clearly visible on the horizon are governmental threats to reduce funding for undergraduate and postgraduate medical education. Sooner or later someone has to realize that by castigating and vilifying the medical profession, driving those that can leave away, and those that can't deeper into a latter day Slough of Despond, and by cutting off the life blood at its source, that health care may suffer the

same fate as the education system in this country. For years teachers have been underpaid and their plight unrecognized — now illiteracy is rampant. If these forebodings on the future of medicine materialize we may face not only Doctors who can't read, but no Doctors.

So far the public has been fed a line by a short-sighted self interested government who cannot see beyond the next election, and is delighted to have found a scapegoat that so far is rolling over and playing dead. It's time we stood up, and through our Medical Society, lobbyists and-horrors-if necessary unions, put forth our points of view. We still have the chance to keep medicine a vocation worthy of practice. □

Nicholas P. Coe, M.D., FRCS

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John L. Powell, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	April 7, 1942
PREMED:	Davidson College, N. Carolina 1960-64
MEDICAL:	University of North Carolina 1964-68
INTERNSHIP:	Tripler General Hospital 7/68 - 6/69
RESIDENCY:	Fitzsimons General Hospital, Denver 1969-72
FELLOWSHIP:	Crawford W. Long Memorial Hospital, Georgia 1976-78
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SPECIALTY:	INTERNAL MEDICINE

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RESIDENCY:	Loyola University 7/83 - 6/84 Baystate Medical Center 7/84-present time
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759 Chestnut St.
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BORN:	December 16, 1956
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MEDICAL:	SUNY at Stony Brook, NY 1979-83
INTERNSHIP:	Baystate Medical Center 1983-84
RESIDENCY:	Baystate Medical Center 7/84 - present time
SPECIALTY:	OBSTETRICS/GYNECOLOGY

Joseph H. Donnelly, M.D.
140 High St.
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BORN:	March 24, 1947
PREMED:	Harvard College 1964-68
MEDICAL:	Georgetown University School of Medicine 1968-72
INTERNSHIP:	Boston City Hospital 1972-73
RESIDENCY:	Boston City Hospital 1973-74
FELLOWSHIP:	Boston University 1974-77
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Clinical Trials and the Ethics of Patient Care

In many diseases, treatments exist which produce predictable and quite satisfactory results: An appendectomy for acute appendicitis, the administration of hormone replacement for hypothyroidism. There are other situations where, although the treatment is unsatisfactory, limitations in our understanding of the pathophysiology or our ability to manipulate the molecular biology, require advances in areas not directly related to the expertise of the practicing physician: Coronary artery disease, severe rheumatoid arthritis. There are many entities, however, where treatment is not satisfactory, *and* there is an adequate understanding of the pathophysiology so that information can be gained by enrolling the patient in a controlled clinical trial. Obviously, many categories of malignant disease fall into this category. It is in these circumstances where seemingly difficult ethical dilemmas arise.

Where there exists a conventional treatment which produces results substantially less than desirable, does the practicing physician have an ethical obligation to encourage his/her patient to participate in a controlled clinical trial of a treatment which has the possibility of improving, overall, the outlook for that disease? When a patient has exhausted standard conventional therapy, should the physician simply lay out alternatives allowing the patient to select one, or should the patient be encouraged to enroll in a trial of semi-experimental therapy? When a patient has exhausted conventional therapy, is it acceptable to administer a treatment using conventional agents for somewhat unconventional indications, or in somewhat unconventional ways, without participating in a clinical trial?

Obviously, there are no simple yes or no answers to the above questions. Certainly, the physician needs to consider cost factors, the physical and emotional health of the patient, the acceptability of further toxicity for questionable gain in a patient with a terminal illness, and so on.

Several medical philosophers have advanced "models" of the doctor-patient relationship, which of course lies at the root of the above issues. A brief examination of some of these models is sufficient to see that none is perfect, and furthermore, all avoid addressing the societal aspect of the doctor-patient relationship.

There are a number of models (contractual, economic) which propose that a physician is no different than any other professional, and the relationship between doctor and patient is simply one for which a service is contracted for. These models see the physician's role as that of a technician, not essentially different from the relationship between a mechanic and a client. In practice, however, physicians and patients both recognize that the limitation in this model is that contractual relationships assume a certain equality of the two parties. However, a sick person is fundamentally different from a well one.

In the memory of many of us, the prevailing model was a "pater-

nalistic" one. Here, the physician became responsible for part of the patient's life, namely his illness. Under this model, it was not necessary to inform the patient, to offer the patient options. The physician acted like a parent who knew best, and was expected to exert his/her efforts to bring about improvement in the patients' condition, not necessarily with the patient's informed consent or understanding. Sometimes we long for the good old days!

Currently there is a vogue for an "autonomy" model. Here, the physician (in theory without any coercion) lays out options to the ill individual, who then chooses whether or not to accept treatment. The patient is the guide for the physician.

This is an attractive model, since all of us accept in principle that we should have the final say over what happens to our bodies. However, the greatest flaw in the autonomy model is that the sick patient has a contracted world-view, precisely because of the sickness, and may indeed choose "wrongly" because of this. Few of us would feel comfortable if a young mother with a small breast mass refused to undergo biopsy, or if a productive and vigorous individual refused to receive antibiotics when a diagnosis of uncomplicated diplococcal pneumonia had been made. We would probably exert every effort to persuade (coerce) the individual to accept treatment, and thus

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violate the autonamy model.

Most physicians, and probably most ill patients, would accept the fact that there are circumstances in which the desires of the sick patient should be overriden for his/her own "good" and for the good of society. The death of a mother with a small breast cancer who with appropriate treatment might have a 95% chance of cure, is a blow to her family, and indeed may affect society as a whole in many ways. This sort of situation has been addressed by the courts. There are circumstances where a Jehovah's Witness has been ordered by the courts to receive blood, or where a Christian Scientist has had to submit to vaccination. Recently, fundamentalist parents were convicted of negligent homicide when they discontinued insulin for their child with juvenile onset diabetes. With respect to members of the armed forces and inmates of prisons, there is no right to refuse medical treatment. In all of these situations, the patient autonomy was overriden.

Besides the implicit recognition that a physician-patient relationship must perforce include society as a whole, another aspect of this relationship is that of "sympathy". The physician not infrequently faces a situation where disability or suffering cannot be significantly alleviated. Where the doctor-patient relationship is a contractual one, a paternalistic one, or based on patient autonomy, it would logically follow that at this point the relationship should cease. Yet we all recognize that it is in such a situation that our patients seem to need us the most. The physician is a professional who "suffers with" (Greek, *syn pathos*) the patient in a special way. When death from disease is inevitable, the patient desperately needs the sense that someone who knows about the illness continues to urgently look for answers, not simply out of curiosity, but because he or she has a personal stake in wanting the patient cured or palliated. The physician gives this assurance in non-verbal ways, with gentleness, with the preservation of hope, and usually avoids outright statements of fact regarding the terminal condition. The fact that we continue to attend terminal patients, to feel pulses, listen to chests, prescribe renewals of narcotic medications, even when much of what we do need not be done, and other parts could be done over the phone, is a recognition that this type of contact is important for both the doctor and the patient. These kinds of actions give hope, and giving hope to the hopeless is a central part of our profession.

Physicians dealing with cancer patients frequently explain why they do not enroll patients in clinical treatment trials in several ways:

1. "I can treat the patient with the regimen without enrolling him/her in a study".

While this is often true, and indeed, while this approach saves some time and paperwork, the physician, the patient, and society all lose by this strategy. The physician delays the time it will take to answer the question addressed by the study; thus by his action, he/she delays the arrival of the time when he/she can make an intellegent decision about this treatment for his patients. The patient loses the opportunity to be a partner in discovery. I rarely have met a patient who is not willing, and even enthusiastic, about participating in a clinical trial when

the trial is properly explained, and when the issue of advancement of knowledge about his disease is emphasized. The patient is not merely being altruistic; he may hope that some vital fact may be uncovered by this trial which might help his own case. Society loses, of course, because in addition to the negative effects of this strategy on the advancement of knowledge, there is the issue of whether society, which pays the bills, is getting optimal return for its investment. A patient treated with a studied regimen, but not enrolled on the study, is going to run up roughly the same medical bills as if he/she were so enrolled, but the "side effect" of getting the answer to the question would greatly increase the return on the investment.

2. "The regimen will not *really* affect the inevitable outcome".

This is very frequently true, especially in terms of the testing of new agents. Yet, perversely, the best protocol accrual is precisely to those studies of new agents and novel therapies. A broader argument rages in the oncologic community: Should we evaluate regimens by whether they improve survival or whether they increase the fraction of patients who undergo a regression of disease? For example, it is doubtful that intensive combination chemotherapy is better than single agent therapy in the treatment of advanced ovarian cancer, when measured by survival statistics. On the other hand, combination therapy demonstrates a very significant increase in the fraction of patients undergoing complete and partial disease remissions. The real answer to this dilemma is to rephrase the question; as we justified in

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considering something "standard" when the outcome is poor for the whole population of patients being treated? If we are not so justified, then it is logical to build upon that which produces the best objective regression of disease, and *that* it implies that a reasonable study should take priority over so called "standard" therapy. We do a disservice to our patients by relegating them to an approach we know has a poor long term outcome, when there are studies in which it is *possible* that a better outcome might be achieved. Patients, when explanations of clinical research programs are made to emphasize this, are usually willing to try the new, rather than stick with the old.

3. "It is wrong to put the patient on something that will get their hopes up, only to have those hopes dashed once again".

If we see part of our role as giving hope, we see that there is merit in enrolling patients on treatment protocols precisely to give them hope. Even when fully informed, a patient who is receiving an investigational drug to which there is no reasonable expectation of cure or significant response, can legitimately tell himself, while undergoing treatment, that there is a small ray of hope. To many patients, this is a much better way to live than to simply wait for the inevitable. Hope is what the patient purchases from the naturopath or the Laetrile pusher. Certainly, it is better for all concerned if their hope, however small, is based upon reasonable science.

In conclusion, physicians should actively encourage their patients to enroll in clinical trials for a variety of reasons. Of course, there are circumstances where it is legitimate to stop treatment, and of course some balance must exist between what might be achieved and what the cost is to the patient. The caring physician needs to fully understand the rationale, toxicity, probability of response, costs, etc. of any clinical trial in which he/she participates. But it does seem unfortunate that there are so many questions remaining in medicine, and at the same time, a continuously dwindling enthusiasm for answering them on the part of practicing physicians, without whom these questions will never be answered. □

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Executive Committee Meeting Report

A meeting of the Executive Committee of the Hampden District Medical Society was held on Monday, December 17, 1984 at the Society's office. The meeting was called to order at 7:30 p.m. by Dr. Asinas, President-Elect.

Present were: Drs. Asinas, Hough, Hutt, O'Neill, Pacosa, Remsberg, Ryan, Stoler, Walthall, Mrs. Kiss, Auxiliary President, and Mrs. Nystrom. Invited Guests: Drs. Howard Gold and Alicia Ross, Mr. Steven Wesler of Robert Donnell Productions.

The minutes of the November 19, 1984 meeting were approved as written.

OLD BUSINESS:

1. *Infant Mortality Statistics:* Dr. Howard Gold, Chairman of the Public Health Committee, outlined the work done to date by Western Mass. Health Planning Council in reviewing the problem of high infant mortality statistics in Holyoke and Springfield. As a result of this work, Dr. James Egan had sent a report to the Director of Family Health Services at the Mass. Dept. of Public Health in October, suggesting changes in the reporting of infant mortality statistics. The Public Health Committee felt Dr. Egan's excellent report should be sent to the Perinatal Welfare Committee of Mass. Medical Society for their review. Dr. Gold read his proposed covering letter and asked the Executive Committee for approval to send the material to the Mass. Medical Society. Dr. Gold's letter was approved and will be sent with Dr. Egan's report to the Chairman of the MMS Perinatal Welfare Committee and to Dr. Duncan, President of MMS.

Dr. Gold read the following motion from the Public Health Committee:

MOTION: As a result of our investigation into the problem of perinatal mortality, the Public Health Committee endorses all vigorous efforts to address and prevent the tragedy of unwanted teenage pregnancies.

We also endorse programs by the school systems and the communities to make possible and practical meaningful educational programs for teenage mothers so as to prevent subsequent unwanted pregnancies and to help educate and to increase the quality of life for these mothers and infants.

The Executive Committee unanimously approved this motion, as written.

2. *Computer show:* Mr. Steven Wesler of Robert Donnell Productions was present to discuss HDMS participation in a computer show on May 1, 1985 at the Springfield Civic Center. Mr. Wesler suggested a one day seminar to run from morning to noon with a one hour break and then reconvene for an afternoon session. He offered a room to

continued on next page

hold the seminar and said he would immediately begin researching medical software to obtain four suggested topics. HDMS could pick one as the theme for the seminar. The Executive Committee approved participation in the computer show by having a seminar.

3. *Letter from Dr. Coen, Scholarship Committee Chairman:* Dr. Coen felt the Scholarship Committee should proceed as in the past by giving each deserving applicant an equal share of whatever monies are available. Because of the great need of each student applying, any amount we give as scholarships is being gratefully received. The Executive Committee accepted Dr. Coen's letter as informational.

4. *Copy Machine:* A new Ricoh copy machine is on line and working in the office. Dr. Stoler was given a vote of thanks for his help in obtaining the machine from Bloom's, Inc.

NEW BUSINESS:

1. *Dinner for Area Women in Medicine:* Dr. Alicia Ross received a request from Dr. Euginea Marcus, Chairman of the MMS Women in Medicine Committee, to begin a drive in this area to recruit women physicians to medical society membership. There are approximately 40 women physicians in this area who do not belong to HDMS. Dr. Marcus had suggested a dinner meeting and had offered her services as speaker. MMS would help defray costs. HDMS would select date, location and menu. After discussion, the Executive Committee approved holding the dinner. Dr. Ross will be in charge of arrangements.

2. *Budget:* Dr. Remsberg reviewed the proposed budget for 1985-86. The budget was unanimously accepted by the Committee.

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Dr. Remsberg's suggestion of a "No Dues Increase" stamp for the dues bill envelopes was approved. Also approved was his suggestion that the sheet, "What Your District Society Does For You", be included in the dues mailing and printed in the February/March issue of the Hampden Hippocrat.

3. Dr. Smith's Special Report will be discussed in January.

4. Business Meeting Format of District Meeting will be discussed in January.

5. *Bylaws Committee - New Chairman;* It was announced that the new Chairman of the Bylaws Committee will be Dr. Bruce Stoler.

6. *Public Health Committee Motion on Nuclear Warfare:* Dr. Gold read the following motion from the Public Health Committee:

MOTION: The Public Health Committee recommends to the Hampden District Medical Society President, Dr. Lorne C. Smith, that he appoint a Task Force to look at the issue of the risk of nuclear warfare and have this Task Force propose educational efforts within our Society and collaborate with other institutions to present an educational program to the community.

After discussion, the following motion was passed unanimously:

MOTION: The Executive Committee recommends that the Public Health Committee consider the issue of the risk of nuclear

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war as an appropriate area of consideration for their committee. It is further recommended that a subcommittee of the Public Health Committee act as a Task Force to propose educational efforts within our Society and the community.

Mrs. Kiss reported she had received a call from, "Action Against Chemical Abuse" (i.e. drugs and alcohol), asking if HDMS or the Auxiliary would be interested in supporting this group with seed money. As alcohol and drug abuse is the next topic the Public Health Committee is planning to review, with a representative of the Alcoholism Services of Greater Springfield being invited to speak at their January 15th meeting, it was suggested that Mrs. Kiss or Mrs. Miller present the request to the Public Health Committee on that date. Dr. Gold extended an invitation to Mrs. Kiss to attend the January 15th Public Health Committee meeting.

7. *Health Care Committee Motion on Denials of PRO Claims:* Dr. Hough read the following motion from the Health Care Committee:

MOTION: The Health Care Committee recommends to the Executive Committee that they consider the possibility of the Society collecting from the membership the denials of PRO claims to review the effect on the quality of care.

Dr. Hough said the AMA has set up a Committee to receive DRG denials in order to try to document specific instances of restriction of

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appropriate medical care. After discussion, the following motion was passed unanimously:

MOTION: The Executive Committee recommends that the Health Care Committee develop a protocol for collecting denied PRO claims from the Society's membership and proceed with the project.

8. Dr. Smith's motion on applications for hospitalization and surgery to be granted only by physicians will be discussed in January.

REPORTS:

Dr. Hough gave highlights of the December AMA Meeting held in Hawaii:

AMA will support Mass. Medical Society in its Blue Shield Suit if it goes to the Supreme Court.

Health Care Bank IRA was endorsed and will be promoted. Dr. Hough said, "This would be one answer to the fiscal fiasco of Medicare."

On PROs the Judicial Council warned about the ethical dangers of rewarding physicians for underutilization. They stated it was unethical for a doctor to be directly paid for not providing treatment.

The Judicial Council opposed risk sharing arrangements between hospitals and medical staffs under the DRG approach to prospective pricing.

Dr. Hough said Relative Value Studies are becoming popular again.

The AMA will call upon the Federal Government to restore cuts made to Maternal and Child Welfare.

A ten percent dues discount has been approved for AMA members who belong to unified societies. AMA will set up a special staff to work with unified societies. Dr. Hough felt HDMS should consider this.

Boxing was opposed by the AMA delegates.

The AMA will begin an educational campaign to improve the public image of physicians.

The Judicial Council stated that a doctor has an obligation to tell a patient if he has an interest in a health care facility where treatment will be given in order that the doctor will not deceive or exploit the patient for personal gain.

The date for the next meeting will be Monday, January 21, 1985 at 7:30 p.m.

There being no further business, the meeting was adjourned at 9:30 p.m. □

W.W. Walthall, Jr., M.D.

Notes and Quotes of Interest

MEMBERS NEEDED:
The Public Health Committee is forming a Task Force on the Medical Aspects of Nuclear War. One of our appointed goals is to recommend educational programs to the Medical Society.

Representation to all viewpoints is needed. We welcome your help and opinions. Call Dr. Doug Barnshaw at 787-5400 or Carol Nystrom at 736-0661. Please let us hear from you!

The Mass. Medical Society has notified us that we may have additional Councilors this year. We have three slots open. The Mass. Medical Society Council holds three meetings annually. The meetings last one day and are held in October, February and May in Dedham, Mass. Any HDMS member who wishes to be a Mass. Medical Society Councilor please call Carol Nystrom at the Socley Office - 736-7301.

The freeze on physician reimbursement under the Medicare program has forced the nation into a two-tier system of medical care in which Medicare patients become "second-class citizens," the AMA said in a brief filed in U.S. District Court in Indiana. The AMA said it was challanging the Medicare provisions of the Deficit Reduction Act of 1984 because it "profoundly alters and dramatically enlarges the role of government in the delivery of health care." The AMA originally filed suit last fall, challenging provisions of the law that froze fees and required physicians to decide by Oct. 1 whether they would accept assignment in all Medicare cases. The brief stated that "freedom to select one's own physician without government interference is a fundamental aspect of the constitutionally protected right to privacy" and that the law interferes with that right.

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The Massachusetts Medical Society has been contacted by Thomas H.D. Mahoney, Ph.D. concerning a delegation of New England Health and Aging Experts who will travel to Finland, Russia and China from April 6-27, 1985. The trip, which is open to interested MMS members, is a Goodwill People to People Travel Program, and not a Massachusetts Medical Society sponsored program.

As stated in the Goodwill People to People Travel Program literature: "People to People is an internationally recognized organization, founded in 1956 by President Eisenhower. Mrs. Dwight D. Eisenhower remains the Honorary Founder. Following its original philosophy, the organization has remained almost exclusively private...U.S. groups are usually organized with similar interests or professional backgrounds to travel abroad for an approximate three-week period to meet with counterparts in foreign countries...and exchange information and ideas. These trips have been very successful and quite rewarding for individual pariticipants."

Cities to be visited include Helsinki, Leningrad, Kiev, Moscow, Beijing, Nanjing, Suzhow and Shanghai. Approximate cost of the three-week trip is $4,000.

For more information, contact the MMS Department of Education, 1440 Main Street, Waltham, MA 02254, telephone 893-4610.

In its suit challenging provisions of the Deficit Reduction Act of 1984, the AMA filed documents examining data on the causes of increased spending on health care. The documents state that "virtually all of (the increased spending)—apparently over 95%—is due to three factors: general inflation, increased Medicare enrollment, and increased utilization of physician's services by Medicare patients. In real economic terms, physician's fees to Medicare patiens have increased very slowly and average charges and reimbursements have been declining." The AMA said that "physicians' fees...measured in constant dollars have been growing by only 1.0% annually since the early 1970s," that physicians' real net incomes have been declining on average (by 0.2% a year)," and that MD's fees to Medicare patients "have grown no faster than other fees, and appear to have grown more slowly."

Gynecologic Oncology

Dr. John Powell has joined Baystate Medical Center's medical staff as chief of the Gynecologic Oncology Service. Powell's talents include expertise in laser cancer surgery, and his presence assures a complete range of services for the treatment of gynecologic cancer.

Isaac Lewin Symposium

The Isaac Lewin Symposium is held annually to provide physicians in Western Massachusetts with a comprehensive educational program dealing with an aspect of cancer. This year it will be held on Friday, March 15, at the Harley Hotel in Enfield, Con-

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necticut. There will be five nationally prominent speakers who will discuss aspects of the natural history, diagnosis, and management of non-small cell bronchogenic carcinoma. The symposium is sponsored by the Hematology-Oncology and the Pulmonary Services of the Department of Medicine at Baystate Medical Center, together with the American Cancer Society. The Lewin Symposium is a memorial to Dr. Isaac Lewin, who founded the Cancer Cooperative, an organization devoted to improving the quality of cancer care in the Pioneer Valley.

Pediatric Oncology

Dr. John Kelleher, the director of Pediatric Hematology-Oncology at Baystate Medical Center, has announced plans to form an affiliation with the Children's Cancer Study Group (CCSG). The CCSG is the largest cooperative group dealing with pediatric malignancies, and includes as members Sloan-Kettering Institute in New York, and the Children's Hospitals of Philadelphia, District of Columbia, and Los Angeles. The CCSG has been a major force in the development of improved treatments for childhood cancer, and the affiliation means that the most up-to-date treatments are available to area children without the necessity for travel to other centers.

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New in this edition are year-end 1982 figures; national trend data on physician location in census regions, primary care specialties, patient care, and foreign medical graduates; physician/population ratios for selected years 1950-1982 and by specialty.

One special tabulation lists the 82 specialty and subspecialty categories reported by physicians. Others rank physician/population ratios by state, list counties without an active physician in patient care, and give board certification data. There are statistics on school of graduation by year of graduation; specialty and activity distributions for women and foreign medical graduates; and physician distributions by regions, counties and metropolitan areas.

Physician Characteristics and Distribution in the U.S., 1983 Edition, costs $35. There is a 10 percent discount for AMA members and a handling and delivery charge of $4 for orders of 1 to 3 copies. For additional ordering information, call the AMA Order Department, (312) 280-7168. □

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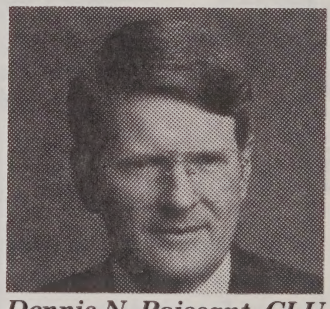

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Business Meeting Report Hampden District Medical Society

The meeting of the Hampden District Medical Society was convened on January 29, 1985, at the Marriott Hotel at 6:05 p.m. by Dr. Smith.

The first order of business was reading of the minutes of the previous meeting by Dr. Walthall and they were accepted as read.

Dr. Remsberg then gave his treasurer's report with the budget for the upcoming year. The bottom line of the budget was extremely close to last year's budget, thus requiring no change in dues. The announcement that there would be no dues increase was welcomed by those present.

Dr. Barnshaw was then recognized to make an announcement. He requested support for a Hampden District meeting in the future with the theme of our concern with the medical problems which would be brought about by nuclear war. He requested suggestions for a speaker for that meeting.

Dr. Smith then stated that the AMA was establishing a mechanism for referral of problems encountered by physicians and their patients with the new PPO restrictions. The local Hampden District Committee on Health Care chaired by Dr. Gary Hough will receive and compile the problems cited locally.

Dr. Smith then initiated a discussion of the recent difficulties cited in the press concerning high infant mortality rate in the Hampden district area and its relation to poor Medicaid participation by the local physicians. He pointed out that the poorest statistics cited by the press occured prior to 1983 when most OB-GYN physicians in the area were participating in the Medicaid program. The problems which arose in 1983 with the demand for a signing of a provider agreement and the change in the fee schedules which led to a lesser participation in the Medicaid program obviously cannot be blamed for an aberration in the infant mortality rate which had occurred in the years preceding that. It was pointed out that there was a tendency in the press and on the part of some public officials to equate the low participation in the Medicaid program with the higher than normal infant mortality rate ingnoring the fact that the time periods in which these occurred are different.

To solve the problem of low participation in the Medicaid program by the OB-GYN specialists, the suggestion that a local clinic manned by them be set up for Medicaid recipients. This attempt at solving the problem was misinterpretted by the Massachusetts Commission Against Discrimination and its local Commissioner, Mr. Hurst, as a discriminatory gesture, thus leading to a press release. On this basis Commissioner Hurst publicly requested patients receiving medicaid

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to come forward with complaints against physicians so that he may pass those complaints on to the Attorney General's office. The legal issues involved in here appear to be obscure, but the extremely bad public relations that would result in such an incident would best be avoided.

Dr. Smith went on to say that the position of the Medical Society was to offer the services of the Medical Society to assist any Medicaid patients, who could not find appropriate sources for care, to find care. The few patients that came forward with such problems then were taken care of by the Medical Society. Interstingly, none of the patients who came forward were complaining of the inability to obtain obstetrical care. He went on to say that he and several representatives of the Medical Society would be meeting with Commissioner Hurst shortly to attempt to resolve, at least on a short term basis, some of the problems.

At this point Dr. Smith asked Dr. James Egan, representing the OB-GYN physicians, to discuss their investigation into the claim of excessive neonatal mortality.

Dr. Egan began by pointing out that it has been approximately one year since the accusation about the excessive neonatal mortality had hit the press. The obstetrical and pediatric local community were taken by surprise, because they had felt that our local statistics had been very good, perhaps as good as any in the nation. Dr. Egan went on to say that it took them four or five months before they began to appreciate why there was such a discrepancy.

Putting things in perspective, Dr. Egan said that the infant mortality rate in Massachusetts as a whole is very good and is essentially at the target level for the country for 1990. We are attempting to live up to a very high standard of care. They investigated the infant mortality

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rates from 1978 to 1983. They found that in Springfield the infant mortality rate peaked in 1980. The infant mortality rate has been coming down each year since 1980. During that period of time the vast majority of the OB-GYN physicians in the area were participants in the Medicaid program. Dr. Egan pointed out that the reason for the discrepancy in the infant mortality rates has occurred because the local hospitals have been counting the infant mortalities only on those babies born with a birth rate of 750 gms., whereas the international standards require that all babies born with any signs of life be counted. In reviewing the statistics Dr. Egan stated that 63% of the infant mortality occured in infants weighing less than 2 pounds 3 ounces. As in most areas the greater portion of infant mortality was due to very low birth weight.

Looking into the problem, Dr Egan stated that the difficulties with very low birth weight infants were due to crowding and understaffing of the local neonatal nursery. In the past 2 years these nurseries have been remodeled to give greater work area and have had increased staffing, and there has been a sharp turn around in the low birth weight mortalities.

In conclusion, Dr. Egan stated there has been a problem, but the problem has been greatly magnified. Local statistics have been compared to countries like Costa Rica. Here a 750 gm. infant is carefully monitored and all attempts are made to keep that infant alive,

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whereas in a country like Costa Rica it is simply considered a still born with no thought of saving the infant's life. It is not fair to compare a very sophisticated medical system with a very unsophisticated medical system. Dr. Egan continued by saying there had been dramatic improvements in the neonatal infant mortality rates in 1982 and 1983, and that the pediatricians and neonatologists deserve great credit for this.

Dr. Smith thanked Dr. Egan for his very informative discussion and asked Dr. Zadworny, representing the Western Massachusetts OB-GYN Association, to come forward with his comments. Dr. Zadworny began by stating that they do not believe that there are any patients being denied obstetrical care in this area. He said there are clinics both at Wesson Women's Hospital and Providence Hospital and at the Riverview Clinic and there are at least four private offices continuing to see Medicaid patients. Dr. Zadworny stated that the $508.00 global fee paid by Medicaid for the care of an obstetrical patient does not always cover the physician's expenses in caring for the patient. Dr. Zadworny stated that the fee problem is not the major problem between the OB-GYN specialists and the Medicaid Department, but the constant harassment and audits have turned off the obstetrical community. The solution to the problem such as private clinic staffed by the OB-GYN physicians of the area or a limitation as to the proportion of Medicaid patients seen in a private office to make the distribution equitable amongst the various OB-GYN physicians have been turned down by the state authorities and termed discriminatory. Dr. Zadworny finished by stating that they are having ongoing discussions with the state authorities and they are looking for some give and take from them, but found the state authorities to be intransigent.

Dr. Smith thanked Dr. Zadworny for his explanations. He stated that we must not lose sight of the fact that we are first of all physicians, that our role is to care for patients and we must not let our differences with the state cause any patients to go without the care that they need. □

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SPEAKER:	THOMAS SHELDON, M.D.
SUBJECT:	INTRA-OPERATIVE RADIOTHERAPY
DATE:	APRIL 8, 1985
WHERE:	PROVIDENCE HOSPITAL
TIME:	7:30 P.M.
CME DATA:	2 hours Category I, Springfield Academy of Medicine

Dr. Sheldon is Instructor in Radiology, Harvard Medical School Radiotherapist, New England Deaconess Hospital. □

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Letter to the Editor

Dear Physician,

This letter is to bring you up to date on the Hospice-Related Home Care Program of the Visiting Nurse Association of Springfield. This program is family-centered with its approach focused on the physical, emotional, spiritual and economic issues which impact the quality of life during its final stages, as well as through the bereavement period. V.N.A. Hospice-Related Home Care is medically directed and nurse coordinated with services available on a 24 hour, 7 day-a-week basis. The success of our program depends to a great extent upon physicians like yourself. As the primary caretaker of the patient/family unit, your interest in and endorsement of the concept of hospice is essential.

We are pleased to announce Dr. Paul Nay as our new Medical Advisor. He is Vice President and Chief Medical Director of Mass Mutual Life Insurance Company in Springfield. He is a graduate of Temple University School of Medicine and had a practice in Internal Medicine in New York before joining Mass. Mutual.

He joins a team of interdisciplinary caregivers dedicated to providing the best possible home care to the terminally ill patient/family. The team consists of two VNA staff nurses, Maureen Maloney RN, and Debra Walker RN, who are skilled in the nursing care of the terminally ill person. The program is coordinated by a clinical nursing supervisor, Elizabeth Young RN, BSN (acting). The Supervisor of Volunteer Services, Edith Dorang M.Ed., C.A.S., LCSW, and the individual volunteers, are a vital component of the team. Medical Social Services are provided by Sandra Wolosenko MSW, and Pastoral Care Services by Pat Masi PCG. To date, we have provided services to approximately 100 Hospice-Related patients. The team meets weekly to discuss each case. You will be given feedback about your patient and are very welcome to participate in team conferences.

We, or any member of the Hospice Team, are available to speak with you or your staff by telephone or to meet with you at your convenience to discuss the program, individual cases, and to see how we may be of help. For further information or to make referrals for service, call the Visiting Nurse Association of Springfield at 781-5070. □

Sincerely,

Paul Nay, M.D.
Medical Advisor to the V.N.A. of Springfield's
Hospice-Related Home Care Program

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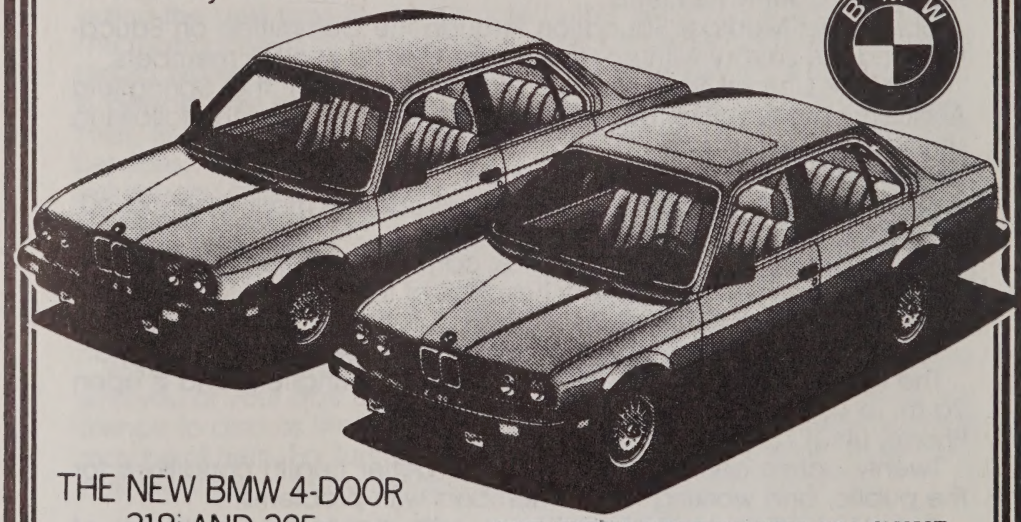

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